Fairview High School Band

Health Treatment and Medical Treatment Permission 2021-2022

NAME _____ BIRTH DATE _____

To Whom It May Concern:

I, the undersigned, being the parent, legal next-of-kin, or legal guardian of _____ hereby authorize any necessary medical treatment for this person while participating in the Fairview Band activities. I, also, guarantee payment of all charges incurred during medical treatment.

In regard to such person, I submit the following information:

1. Allergies to foods, medications, etc. (If none, so state)

_____

_____

2. Special medical problems or health conditions. (If none, so state)

_____

_____

3. Medication or prescription to be used by student. (If none, so state)

Medication _____

Purpose _____

4.Student **MAY** or **MAY NOT** take Aspirin Substitute as a minor medication. (Circle One)

5.Date of last Tetanus Shot (If unknown, so state) _____

6.Family Physician _____ Phone _____

Office Address _____

(Street) (City/State) (Zip)

7.Person, other than parent or guardian, to notify in case of an emergency:

Name _____ Phone _____

8. Parent/Guardian Name

_____

Address _____

(Street) (City/State) (Zip)

Home Phone _____

Work (Father) _____ Work (Mother) _____

Parent/Guardian Signature _____

Fairview High School Band

2595 Fairview Blvd W Fairview, TN 37062

Nick Heilborn

Director of Bands

Subscribed and sworn by parent/guardian before me.

_____ Day of _____, 2021

Notary Public: _____

Commission Expires: _____